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MEMBER ACCESS AND AUTHORIZATION FORM

For your child's privacy protection, we will not disclose, obtain, or exchange their personal health information unless you give us permission to do so or unless the law requires us to do so. We know that you may want access to your child's care notes or need to share their information with others to support their continuity of care or for other reasons. To do so, we need your written permission.

Client (child) Name:_____ DOB: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone number: _____ Email: _____

I authorize Brightline, Inc. and any of its managed entities, including Brightline Medical Associates, P.A., Brightline Medical Associates of California, Inc., Brightline Medical Associates of NJ, P.A., or Brightline Medical Associates of KS, P.A. (collectively, "Brightline") to release information to:

☐ Self
☐ Parent / Legal Guardian
(if Parent/Legal Guardian address differs from child's, please complete address below)
☐ Other
(if sending to another medical provider, please complete address below)

Please enter the address where you would like medical records mailed below (if different than above):

Name: _____

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Mailing Address: _____

City: _____

State: _____

Zip: _____

Phone: _____ Fax Number: _____

Under the conditions listed below:

1. This information will be limited to:
   - ☐ Treatment Summary
   - ☐ Coaching Welcome Session (Intake)
   - ☐ Coaching Session Guide
   - ☐ Therapy Intake/Evaluation
   - ☐ Therapy Progress Notes
   - ☐ Any and all records
   - ☐ Assessments
   - ☐ Psychiatric Evaluation/Progress Notes
   - ☐ Other: _____

2. Purpose or need for such disclosure:
   - ☐ Self [Member Right to Access]
   - ☐ At the request of the individual/patient
   - ☐ Continuing care/treatment
   - ☐ Other: _____

3. Dates of Service:
   - ☐ Any and all care notes
   - ☐ Specific dates: _____

Authorizing the exchange of this information is voluntary. The child's treatment, payment, enrollment, or eligibility of services will not be conditioned on whether or not this authorization is signed. I understand that any information disclosed pursuant to this authorization may be re-disclosed by a recipient and may no longer be protected by federal and state health

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information privacy laws. I understand that Brightline cannot guarantee that health information sent electronically will be confidential. I further understand that I have the right to revoke this authorization at any time by sending written notification to care@hellobrightline.com and that a revocation of this authorization is not effective to the extent that action has already been taken in reliance upon this authorization. **Unless sooner revoked, this authorization to release or disclose expires one year from the date of signature. An individual's Right to Access request does not expire.** An additional consent must be obtained for any other transfer or disclosure of this information. I understand that I may receive a copy of this release.

If signing on behalf of the patient as an authorized representative:

Your name: _____

Your address: _____

Your telephone number: _____

Your relationship to the patient:

- ☐ Self
- ☐ Parent or legal guardian

  *By signing this form, you acknowledge that you have legal authority to provide consent to the use or disclosure of medical records and have attached a copy of documentation to support this authority.
- ☐ Other, specify: _____

Signature: _____ Date: _____

Email the completed form to care@hellobrightline.com. Our staff will need approximately 15 business days to retrieve and prepare the records. Please note this may take longer in December. If you need records by December 31, 2024, we recommend returning the form no later than December 1, 2024.